Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 4, 2014	2014_242171_0006	L-000283-14	Resident Quality Inspection

Licensee/Titulaire de permis

BABCOCK COMMUNITY CARE CENTRE INC.
196 Wellington Street, P.O. Box 190, Wardsville, ON, N0L-2N0

Long-Term Care Home/Foyer de soins de longue durée

BABCOCK COMMUNITY CARE CENTRE
196 Wellington Street, P. O. Box 190, Wardsville, ON, N0L-2N0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ELISA AGNELLI (171), NANCY SINCLAIR (537), REBECCA DEWITTE (521)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 17,18,19,20,21,25,26,27, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Quality Improvement Coordinator, Food Services Supervisor (FSS), Registered Dietitian (RD), Activity Director, Administrative Assistant, Maintenance Worker, 5 Registered Nurses (RN), 2 Registered Practical Nurses (RPN), 13 Personal Support Workers (PSW), 2 Housekeepers, Laundry Aide, 2 Dietary Aides, 1 Cook, 40 Residents, and 3 Family members of Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, food service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee had not ensured the organized program of nutrition care and dietary services included the development and implementation, in consultation with the Registered Dietitian, of policies and procedures relating to nutrition care and dietary services and hydration.

The following policies were not implemented:

a) The Nutritional Risk Indicators Policy indicated the Registered Dietitian will assess each new resident for Nutrition Risk and that reassessments will be completed by the Dietitian (RD) and/or Food Service Supervisor (FSS), no less than quarterly to determine if classification is appropriate.

On March 25, 2014 a review of the plan of care for Resident #776 indicated a documented Nutrition Risk Assessment completed in 2009 in Point Click Care showing the resident was at Moderate Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

On March 25, 2014 a review of the plan of care for Resident #802 indicated a

documented Nutrition Risk Assessment completed in 2012 in Point Click Care showing the resident at Moderate Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

On March 25, 2014 a review of the plan of care for Resident #752 indicated a documented Nutrition Risk Assessment completed in 2010 in Point Click Care showing the resident at High Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

Management confirmed Nutritional Risk assessments had not been completed quarterly as per the policy.

b) The Meal Food Temperatures policy indicated the internal temperature of all food items at each meal shall be taken and recorded prior to meal service.

The staff use the Menu Production sheet to record temperatures. It was noted no temperatures were recorded on March 19, 2014 dinner service and most minced or pureed food temperatures were not documented from March 17-20, 2014 at any meal.

The Food Service Supervisor confirmed these temperatures were not documented and confirmed the expectation all temperatures be taken and recorded for every food item.

The following policy was not developed:

c) The Monthly/Quarterly Review Checklist policy indicated the Food Service Supervisor or Registered Dietitian would complete a checklist quarterly of all residents to ensure each resident's Nutritional Plan of Care is implemented, correct and up-to-date.

The Food Services Supervisor confirmed this checklist had not been used. The policy's last review date was October 2012. The current process was described as: At each quarter the Low and Moderate Nutritional risk residents would have the K section of the Minimum Data Set (MDS) completed, however no further assessment was documented in the plan of care and the resident's responses to the interventions in the care plan were not documented.

There was no policy or procedure developed to guide staff regarding assessment of

nutrition care or documentation required for nutrition assessments within the computerized framework the home was using (i.e., RAI-MDS quarterly reviews and Point Click Care). [s. 68. (2) (a)]

2. The licensee had not ensured that the Nutrition and Hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home used Point of Care to record the amount of food and fluid taken by the residents at each meal, however there was no system in place to use this information to evaluate the resident's intake to determine if there was a risk.

On March 25, 2014 Registered staff indicated there were no residents of concern regarding hydration that had been flagged or brought to their attention. A review of the last 14 days fluid intake for Resident #776 indicated less than 1000 millilitres (ml) taken 9/14 days (64% of the time), Resident #802 has less than 1000ml 13/14 days (93% of the time) and Resident #811 had less than 700ml 13 out of 14 days (93% of the time). A previous policy Minimum Fluid Requirement, dated October 2012 indicated any resident with an intake of less than 1125ml per day would be considered at high risk of dehydration.

Management staff confirmed they did not have a system in place to evaluate the fluid intake of residents. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee had not ensured the home's menu cycle had been approved by the Registered Dietitian (RD).

The menu cycle was originally approved October 2013 by the home's RD. Since that time a number of significant changes were made to the menu such as removal of pureed bread from the pureed menu and using mashed potatoes at each meal instead, not making pureed salads, providing half slice of bread instead of a full slice at lunch some days on the regular diet and reducing the serving size of soup. These menu changes would affect the variety of foods on the pureed diet, Canada's Food Guide servings and nutrient content of the menu.

The RD confirmed the adjusted menu had not been reviewed or approved. [s. 71. (1) (e)]

2. The licensee had not ensured an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

Resident #300 was on a diet that could not be met through the home's menu cycle.

The FSS confirmed an individualized menu had not yet been created. Kitchen staff indicated they would prepare foods as requested by the resident, however this has resulted in the resident requesting and being provided items that were not appropriate to the diet order. [s. 71. (5)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the menu cycle is approved by the Registered Dietitian, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had not ensured the written plan of care provided clear direction to staff and others who provide care to the resident.

The care plan section "Adequate Fluid Intake" for Resident #776 indicated a goal of maintaining adequate fluid volume, however did not specify the specific fluid goal for this resident. Staff were not clear regarding how much fluid this individual resident required per day.

The Food Services Supervisor confirmed the goal for fluid intake was not clear in the plan of care. [s. 6. (1) (c)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident #811 had specific requirements for oral care that upon interview revealed were not being completed. Staff interview revealed some of them were unaware of these requirements. The written plan of care did not identify the specific requirements for the resident. [s. 6. (1) (c)]

3. The licensee had not ensured the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A review of the MDS coding for Section K: Nutritional Status for Resident #776 indicated the resident had no dietary concerns.

However, a review of the medical record indicated a mechanically altered diet to aid in chewing, medical treatment for pain and a review of the look back report for the week prior to the MDS assessment indicated the resident's intake was less than 75% at 18/21 (86%) of meals.

The MDS nutrition assessment was not completed in collaboration with all staff involved as the information was not consistent. This was confirmed by the Food Services Supervisor. [s. 6. (4) (a)]

4. The licensee had not ensured the resident was reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the

resident's care needs changed.

a) The plan of care for Resident #776 included a focus of a specific diagnosis with corresponding goal and intervention. A review of Dietitian notes in the progress notes from 2012 indicated the resident was being followed specifically for concerns regarding this potential diagnosis.

As of March 2014 there was no documented reassessment regarding this diagnosis and the diagnosis was not included in the diagnosis list but was included in the care plan. The plan of care had not been reviewed or revised since May 2012 regarding this diagnosis.

Registered staff confirm the resident does not currently have this diagnosis.

b) The Physician's diet order for Resident #776 at admission indicated a specific texture diet. The Dietitian's note in 2012 indicated a change in diet texture. There was no assessment to explain the change in diet texture and the physician's orders had not been updated since that time.

c) On March 26, 2014 a review of Resident # 776's plan of care revealed no documented nutrition assessment or review of interventions in the care plan by the RD or FSS for 7 months. The resident had been assessed at Moderate Nutrition Risk, is on a mechanically altered diet, eats less than 75% of meals and does not meet fluid requirements.

d) On March 26, 2014 a review of Resident #752's plan of care revealed in 2013 there was one nutrition review done at the time of the annual conference in January 2013 and one progress note completed by the FSS in November 2013. This note did not include an assessment of intake of food or fluids or review the interventions in the care plan. The resident had been determined at High Nutritional Risk, is on a mechanically altered diet, requires total assistance to eat, did not eat half of the meals offered in the week preceding the last quarterly MDS assessment. Fluid intake recorded was significantly less than assessed requirements.

Management staff confirmed that residents were not reassessed at least every 6 months for nutrition and hydration risks. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the written plan of care provides clear direction and that staff collaborate in their assessment of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report a suspected allegation of abuse to the Director immediately.

The alleged abuse, resulting from an interview with Resident #811, was reported to the Director of Care by Inspector #521. The licensee did not report to the Director immediately.

This was confirmed by the home's Administrator. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure suspected abuse is immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had not ensured that the organized program of Dietary Services and Hydration was evaluated and updated annually.

A review of the Dietary policies and procedures binder revealed the last revision had been completed in October 2012. Some of the policies referred to the Standards and Criteria which have not been in effect since July 2010.

Management staff confirmed the policies have not been evaluated and updated annually. [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

The plan of care for Resident #800 included interventions to provide specific care. Staff interviewed revealed the resident refused this care 75% of the time. Record review revealed there were no refusals for the care interventions documented.

This was verified with the Registered Practical Nurse. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure Dietary Services and Hydration polices are evaluated and updated annually, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that each resident of the home had his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Six residents interviewed revealed they are woken up in the morning at a different time than their desired waking time.

The morning staff verified these residents were routinely woken up at this time. The care plans do not address the sleep routines of these residents and their preferences. [s. 41.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure each resident has his or her desired bedtime and rest routines supported, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for, (g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee had not ensured all menu items were prepared according to the planned menu.

The therapeutic menu spreadsheet for pureed diets included pureed bread at lunch. It was noted on March 17, 2014 and March 20, 2014 at the lunch meals that this was not prepared and mashed potatoes were given instead. The planned lunch menu on March 20, 2014 for pureed diets included pureed salad. The pureed salad was not prepared and was substituted with green beans.

It was confirmed by the Food Service Supervisor that pureed bread and pureed salad were not prepared as per the therapeutic diet menu. [s. 72. (2) (d)]

2. The licensee had failed to ensure menu substitutions were documented on the production sheets.

March 17, 18 and March 20, 2014 the production sheets indicated pureed bread would be served. This was substituted by mashed potatoes, however this substitution was not documented on the production sheets.

March 20, 2014 the production sheets indicated pureed salad would be served. This was substituted by pureed green beans, however this substitution was not documented on the production sheets.

The Food Services Supervisor confirmed these items were not on the production sheets. [s. 72. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all menu items are prepared according to the planned menu and that menu substitutions are documented on the production sheets, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee had not ensured residents who require assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

On March 17, 2014 at the lunch meal service it was observed the meals for Resident #752 and Resident #777 were set on their tables at approximately 1230h, however no one was available to assist these residents until 1250h.

On March 20, 2013 at the lunch meal service it was observed the soup for Resident #752 was set out uncovered at 1214h, however no one was available to assist until 1227h. Soup was set out uncovered for Resident #783 at 1218h however no one was available to assist until 1229h. This resident's entrée sat uncovered from 1238h to 1244h until assistance was provided.

Management confirmed the expectation that meals are only served when someone is available to provide assistance. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents who require assistance with eating or drinking are only served a meal when someone is available to provide assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee had not ensured that procedures were implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of resident care equipment.

A number of observations were made of unclean commodes left in resident bathrooms.

Management staff confirmed the commodes had not been cleaned after use. The expectation was the policy was to be followed regarding emptying, cleaning and disinfecting the commodes. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure procedures for cleaning resident care equipment are implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure where a drug is to be destroyed it will be destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care.

On March 26, 2014 in the Medication room the Director of Care verified it is the licensee policy to have a team acting together, composed of one member of the registered nursing staff and one other staff member appointed by the Director of Nursing to destroy medications. The Director of Care revealed and confirmed this was not being practiced. [s. 136. (3) (b)]

2. The licensee failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

It was observed on March 25, 26 2014 in the Medication room a box containing medications no longer required for treatment had not all been denatured to such an extent that its consumption was rendered impossible or improbable.

These medications were noted to include, but not exclusively, Warfarin 5mg, Dilantin 100mg, and Nitrolingual 4mg. The medications remained in the package with identifying factors and remained whole.

Management staff confirmed these medications had remained whole and were not destroyed. [s. 136. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure drugs are disposed of by a team and that drugs are altered or denatured when they are destroyed, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A number of unlabelled personal care items were observed in shared resident bathrooms and on the personal care carts. These items included toothbrushes, toothpaste, lipstick, bottles of cologne, electric razors, and jars of petroleum jelly.

Management staff, one Registered staff and one Personal Support Worker confirmed that resident personal care items are not to be shared amongst residents and should be labelled with the resident's name. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On March 25, 2014 the tub room door was observed open and unsupervised by staff for a period of 5-10 minutes. Inside the tub room were products pertaining to the maintenance department. It was verified by staff on duty that it was not the expectation of the home that the door be left open while unsupervised. [s. 5.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On March 27, 2014 wall surfaces were noted to be soiled with dried unidentified substances in the following areas of the home:
Visitor bathroom walls
TV room wall carpet protector
Hairdressing room wall

Registered staff confirmed the walls were soiled. [s. 15. (2) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee had not ensured that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

A review of the home's policies and procedures revealed there was not a policy or procedure in place related to lost items. Missing items were, at times, recorded in a communication book, however there was no tracking in place to determine if items were found and if there were outstanding items missing.

Management confirmed there was not a procedure developed and implemented to report and locate residents' lost clothing and personal items. [s. 89. (1) (a) (iv)]

Issued on this 4th day of April, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Elisa Agnelli

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ELISA AGNELLI (171), NANCY SINCLAIR (537), REBECCA DEWITTE (521)
Inspection No. / No de l'inspection :	2014_242171_0006
Log No. / Registre no:	L-000283-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 4, 2014
Licensee / Titulaire de permis :	BABCOCK COMMUNITY CARE CENTRE INC. 196 Wellington Street, P.O. Box 190, Wardsville, ON, N0L-2N0
LTC Home / Foyer de SLD :	BABCOCK COMMUNITY CARE CENTRE 196 Wellington Street, P. O. Box 190, Wardsville, ON, N0L-2N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOE BABCOCK

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To BABCOCK COMMUNITY CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure that policies related to the organized program of nutrition care and dietary services are developed and implemented in consultation with a Registered Dietitian. This shall include:

a) an updated Nutrition Risk indicator policy, including time frames the Risk Assessments are to be completed for the residents and persons responsible for completion.
b) an updated Nutrition Assessment policy, including time frames the assessments are to be completed, persons responsible, and documentation standards.
c) an updated Food and Fluid monitoring and evaluating policy, including time frames the monitoring and evaluating are to be completed, persons responsible, risk factors and applicable interventions.

Grounds / Motifs :

1. The licensee had not ensured the organized program of nutrition care and dietary services included the development and implementation, in consultation with the Registered Dietitian, of policies and procedures relating to nutrition care and dietary services and hydration.

The following policy was not implemented:

a) The Nutritional Risk Indicators Policy indicated the Registered Dietitian will assess each new resident for Nutrition Risk and that reassessments will be completed by the Dietitian (RD) and/or Food Service Supervisor (FSS), no less than quarterly to determine if classification is appropriate.

On March 25, 2014 a review of the plan of care for Resident #776 indicated a documented Nutrition Risk Assessment completed August 2009 in Point Click Care showing the resident was at Moderate Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

On March 25, 2014 a review of the plan of care for Resident #802 indicated a documented Nutrition Risk Assessment completed July 2012 in Point Click Care showing the resident at Moderate Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

On March 25, 2014 a review of the plan of care for Resident #752 indicated a documented Nutrition Risk Assessment completed February 2010 in Point Click Care showing the resident at High Nutritional Risk. There were no further Nutrition Risk assessments found in the plan of care.

Management confirmed Nutritional Risk assessments had not been completed quarterly as per the policy.

The following policy was not developed:

b) The Monthly/Quarterly Review Checklist policy indicated the Food Service Supervisor or Registered Dietitian would complete a checklist quarterly of all residents to ensure each resident's Nutritional Plan of Care is implemented, correct and up-to-date.

The Food Services Supervisor confirmed this checklist had not been used. The

policy's last review date was October 2012. The current process was described as: At each quarter the Low and Moderate Nutritional risk residents would have the K section of the Minimum Data Set (MDS) completed, however no further assessment was documented in the plan of care and the resident's responses to the interventions in the care plan were not documented.

There was no policy or procedure developed to guide staff regarding assessment of nutrition care or documentation required for nutrition assessments within the computerized framework the home was using (i.e., RAI-MDS quarterly reviews and Point Click Care).
(171)

2. The licensee had not ensured that the Nutrition and Hydration program included a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home used Point of Care to record the amount of food and fluid taken by the residents at each meal, however there was no system in place to use this information to evaluate the resident's intake to determine if there was a risk.

On March 25, 2014 Registered staff indicated there were no residents of concern regarding hydration that had been flagged or brought to their attention. A review of the last 14 days fluid intake for Resident #776 indicated less than 1000 millilitres (ml) taken 9/14 days (64% of the time), Resident #802 has less than 1000ml 13/14 days (93% of the time) and Resident #811 had less than 700ml 13 out of 14 days (93% of the time). A previous policy Minimum Fluid Requirement, dated October 2012 indicated any resident with an intake of less than 1125ml per day would be considered at high risk of dehydration.

Management staff confirmed they did not have a system in place to evaluate the fluid intake of residents. (171)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Order / Ordre :

The licensee shall ensure an individualized menu is developed for resident #300.

Grounds / Motifs :

1. The licensee had not ensured an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

Resident #300 was on a diet that could not be met through the home's menu cycle.

The FSS confirmed an individualized menu had not yet been created. Kitchen staff indicated they would prepare foods as requested by the resident, however this has resulted in the resident requesting and being provided items that were not appropriate to the diet order. [s. 71. (5)] (171)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 24, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure Residents #776 and #752 are reassessed and the plan of care reviewed and revised regarding nutrition and hydration risks by April 24, 2014.

The licensee shall ensure all residents have been reassessed for nutrition and hydration risks and the plan of care reviewed and revised every 6 months or at any other time when the resident's care needs change.

Grounds / Motifs :

1. The licensee had not ensured the resident was reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when the resident's care needs changed.

a) The plan of care for Resident #776 included a focus of a specific diagnosis with corresponding goal and intervention. A review of Dietitian notes in the progress notes from 2012 indicated the resident was being followed specifically for concerns regarding this potential diagnosis.

As of March 2014 there was no documented reassessment regarding this diagnosis and the diagnosis was not included in the diagnosis list but was included in the care plan. The plan of care had not been reviewed or revised since May 2012 regarding this diagnosis.

Registered staff confirm the resident does not currently have this diagnosis.

b) The Physician's diet order for Resident #776 at admission indicated a specific texture diet. The Dietitian's note in 2012 indicated a change in diet texture. There was no assessment to explain the change in diet texture and the physician's orders had not been updated since that time.

c) On March 26, 2014 a review of Resident # 776's plan of care revealed no documented nutrition assessment or review of interventions in the care plan by the RD or FSS for 7 months. The resident had been assessed at Moderate Nutrition Risk, is on a mechanically altered diet, eats less than 75% of meals and does not meet fluid requirements.

d) On March 26, 2014 a review of Resident #752's plan of care revealed in 2013 there was one nutrition review done at the time of the annual conference in January 2013 and one progress note completed by the FSS in November 2013. This note did not include an assessment of intake of food or fluids or review the interventions in the care plan. The resident had been determined at High Nutritional Risk, is on a mechanically altered diet, requires total assistance to eat, did not eat half of the meals offered in the week preceding the last quarterly MDS assessment. Fluid intake recorded was significantly less than assessed requirements.

Management staff confirmed that residents were not reassessed at least every 6 months for nutrition and hydration risks. [s. 6. (10) (b)] (171)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this ~~4th~~ 17th EA day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Elisa Agnelli

Name of Inspector / Nom de l'inspecteur : ELISA AGNELLI

Service Area Office / Bureau régional de services : London Service Area Office